INTRODUCTION

Dear Member:

BlueCross BlueShield of South Carolina (Blue Cross) is pleased to provide your Preferred Blue Plan of Benefits. BlueCross BlueShield provides you and your covered family members with cost-effective health care coverage both locally and on a nationwide basis.

Please refer to the benefits outlined in this Plan of Benefits for all your health care coverage.

The BlueCross BlueShield networks offer the best geographic access to physicians and hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all BlueCross BlueShield Plans participate. For more provider information visit our Web site at www.SouthCarolinaBlues.com.

We welcome you to our family of health care coverage through BlueCross BlueShield of South Carolina and look forward to meeting your health care needs.

VISIT OUR WEB SITE

When you visit our Web site at www.SouthCarolinaBlues.com, you will find several very helpful options. For example, you will find:

- Access to a **Provider Directory** that is updated nightly;
- Access to a list of **Network Pharmacies** through Caremark;
- The latest in health care information from our **News** section;
- **"My Insurance Manager℠".** "My Insurance Manager" allows a member to view the status of personal claims on line and to check how much has been applied toward individual Benefit Year Deductibles and out-of-pocket expenses. You can check authorization status, access information on other health plans you may have with us, check eligibility requirements and even order ID cards;
- And, if you have questions but cannot find the answers on the Web site, you can use the feature **"Ask Customer Service"** to get a response from a BlueCross BlueShield representative.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE:

The benefits you receive will depend on whether the provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum benefits that can be paid if you use Participating Providers and you get pre-authorization, when required, before getting medical care. The amount you have to pay for services and supplies will increase when you do not use Participating Providers and may further increase if you do not get Pre-Authorization.

BlueCross BlueShield of South Carolina makes every effort to contract with physicians that practice at Participating Hospitals. For various reasons, some physicians may elect not to contract as Participating Providers. Non-Participating Providers will be paid at the Non-Participating Provider level of benefits with no protection from balance billing from the provider.

HOW TO GET HELP

How to get help with claims or benefit questions:

- From Columbia, South Carolina; dial 264-0015
- From anywhere else in or out of South Carolina, dial 1-800-760-9290

How to get help on Pre-Authorization:

For MRIs, MRAs, CT Scans, or PET Scans in an Outpatient Facility:

- 1-866-500-7664.

For all other medical care:

- 736-5990 from the Columbia, South Carolina area.
- 1-800-327-3238 from all other South Carolina locations.
- 1-800-334-7287 from outside South Carolina.

Please do not call these numbers for claims inquiries.

Please note that Pre-Authorization is required for the procedures on the Schedule of Benefits that have a "Pre-Authorization" note.

Pre-Authorization for Mental Health Services, Mental Health Conditions and Substance Abuse Services:

Behavioral Health:

- 699-7308 from the Columbia, South Carolina area.
- 1-800-868-1032 from all other areas.

How to get information on Drug coverage:

Drug Coverage is handled by Caremark.

For inquiries regarding the Prescription Drug Benefit please call:

- 1-888-963-7290

For inquiries regarding Specialty Drugs please call CuraScript:

- 1-877-512-5981

For inquiries regarding the status of prior authorization on Specialty Drugs dispensed by CuraScript, please call:

- 1-877-512-5981

You can also access Caremark or CuraScript from our website, **www.SouthCarolinaBlues.com**

For information regarding Prescription Drug Pre-Authorization, QVT Limits or Step Therapy Programs, contact your Human Resources department.

Essential Advocate Questions:
The Corporation provides you and your Dependents with access to 24-Hour Nurse Advisor and Advocacy, a program that includes immediate care with the 24-hour Nurse Advisor plus the unique service of our health advocacy program tailored to bridge the gap between care and Benefits, Provider and patient, and Hospital and home. Members will experience personal support and receive individualized assistance provided by experienced healthcare and Benefit experts. The health advocates assist Members:

- Locating Providers through the BlueCross Doctor & Hospital Finder
- Educating Members on health plan Benefits and how they work
- Researching current treatments
- Resolution of health care claims
- Preparing Members and family members for medical appointments
- Assisting with eldercare issues
- Arranging transportation relating to medical needs
- Navigating the BlueCross website including cost estimator and quality tools
- And much more

Call 1-888-521-2583 to speak with a registered nurse or health advocate.

Health Management Questions:
The Corporation will provide you with access to ***Health Management***, a Disease Management Program for Members with any of the following diseases:

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease or chronic lung problems)
- Diabetes
- Heart Failure
- Coronary Artery Disease
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Migraine

The purpose of this program is to help the Employees understand their risk factors and treatment options, explore healthy lifestyle choices, set and reach realistic health goals and learn to successfully self manage their condition. Members enrolled in this program receive access to a personal health coach, educational resources, and Web tools that help them learn more about their health and how they can better self-manage their condition. Members identified as having any of the above conditions will automatically be enrolled in *Health Management*. Members that **do not** want to participate can opt out. For more information on this program call 1-855-838-5897 option 2.

Healthy® Vision Questions:
The Corporation provides you with access to ***Healthy Vision***, a managed care vision product. Your Benefits include one annual eye exam and one pair of eyeglasses, Frames or contacts every two years. Call 1-866-723-0513 to locate Providers, answer Plan specific Benefit questions, report issues or complaints and Plan limitations and exclusions. Automated information is available 24 hours a day, 7 days a week.

Maternity Care Questions:
The Corporation provides you with access to ***Maternity Care,*** a confidential Maternity Management Program. ***Maternity Care*** will provide individualized feedback to expectant mothers based on your answers to a confidential assessment survey. This unique program will give you access to a maternity nurse who will work with you and your doctor to coordinate your care and provide you with information to help you make the best decisions for you and your baby. Members 18 years of age or older who enroll in this program will receive the following:

- A pregnancy book of your choice
- Newsletters each trimester about prenatal care and healthy habits
- Access to a 24-hour phone line where you can ask a nurse questions about your pregnancy
- Information on breastfeeding, shots for your baby, how to quit smoking, and more!

To participate in this program, call: 1-855-838-5897 option 3.

Complex Care Management Questions:
The Corporation provides you with access to ***Complex Care Management***, a unique patient support and education program which provides you with a registered nurse case manager to assist you in making informed decisions about your health care when you're seriously ill or injured. Participation in the program is voluntary and at no cost to Members. For more information call: 1-800-868-2500, extension 42648.

Personal Health Assessment Questions:
The Corporation will provide you with access to ***Personal Health Assessment***, an on-line health risk assessment that allows members to evaluate their wellness potential and receive instant feedback with suggestions for healthy lifestyle changes. To access Personal Health Assessment visit www.SouthCarolinaBlues.com.

Men's and Women's Health Questions:
The Corporation provides you with access to ***Men's and Women's Health***, a program that offers education and reminders on preventive screenings based on recommended guidelines. If you have not had a standard routine wellness exam and/or screening, you will receive:

- A letter recommending that you visit your doctor to obtain the appropriate care (i.e., physical examination, mammogram, Pap Smear, etc.).
- A Men's or Women's health brochure
- Reminders about preventive screenings and immunizations through the mail
- A Prevention Now Wallet Guide
- Access to a health coach to ask questions regarding men's or women's health topics

This program is offered in partnership with the Informed Health program.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for health care services they rendered to you. However, in the event a provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an Explanation of Benefits (EOB) through our website or by contacting customer service. An EOB will also be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim. Please see this Plan of Benefits for more information.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the web site. Or, call us at the telephone numbers listed on the previous page and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, SC 29202

Please refer to Article XI of this Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Group Contract Number: 25-53784-06 through 08 and 11
Employer: St. John's Fire District
Plan C
Plan of Benefits Effective Date: May 1, 2013

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-810-BLUE (2583) or access our website at www.SouthCarolinaBlues.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on date of employment.
Pre-Existing Condition Period:	Each Member who is age 19 or older on the Enrollment Date must serve a twelve-month Pre-Existing Condition Waiting Period, less any Creditable Coverage the Member can provide. Any member who is a Late Enrollee will serve an eighteen month Pre-Existing Condition Waiting Period. See Article II of this Plan of Benefits for information on qualifying for Special Enrollment.
Dependent Child, in addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of 26.

Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least 30 hours per week. At least 48 weeks per year.
The column to the right identifies other group classifications, as defined by the Employer, that may participate in this Plan of Benefits:	Appointed/Elected Officials
Benefit Year Deductible:	The Benefit Year Deductible is $6,000 per Family with no one Member meeting more than $2,000 for Participating Providers. The Benefit Year Deductible is $30,000 per Family with no one Member meeting more than $10,000 for Non-Participating Providers. Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.
Annual Out-of-Pocket Maximum:	$4,000 per Member, and $8,000 per family at a Participating Provider. $10,000 per Member, and $20,000 per family at a Non-Participating Provider. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums. Benefit Year Deductibles, Copayments, and Coinsurance for Chiropractic Services do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits. If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will not accumulate toward the Out-of-Pocket Maximum.
Restricted Annual Dollar Limit:	$2,000,000 per Member.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is $200 for a Participating Provider and $500 for a Non-Participating Provider.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 03/01.

In the event that two or more Members of one family incur charges for Covered Expenses as a result of injuries received in the same accident, only one Benefit Year Deductible will be applied to Covered Expenses that are incurred by all such Members as a result of injuries sustained in that same accident.

All Admissions require Pre-Authorization. If Pre-Authorization is not obtained, room and board charges will be denied. Other services may also require Pre-Authorization. Please see the Schedule of Benefits and Plan of Benefits for more information.

Pre-Authorization is required for the following outpatient Benefits:
MRI
MRA
CT Scans
PET Scans
Septoplasty
Any surgical procedure that may be potentially cosmetic: i.e. blepharoplasty, reduction mammoplasty
Hysterectomy
Investigational procedures
Mental Health Services
Mental Health Conditions
Substance Abuse Services
Behavioral Therapy related to Autism Spectrum Disorder

Benefits for Behavioral Therapy related to Autism Spectrum Disorder, MRIs, MRAs, CT Scans, and PET Scans will be denied when Pre-Authorization is not obtained or approved by the Corporation. Benefits for any other outpatient services that require Pre-Authorization will be reduced by 50% of the Allowable Charge when Pre-Authorization is not obtained or approved by the Corporation.

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Corporation pays 70% of the Allowable Charge after the Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Copayment	The Corporation pays 50% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services)	The Corporation pays 70% of the Allowable Charge after the Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Copayment	The Corporation pays 50% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services when Pre-Authorized by the Corporation and performed at a Provider designated by the Corporation	The Corporation pays 70% of the Allowable Charge after the Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Copayment	The Corporation pays 50% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, limited to 60 days per Benefit Year (Pre-Authorization is required)	The Corporation pays 70% of the Allowable Charge after the Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Copayment	The Corporation pays 50% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Long Term Acute Care Hospital (Pre-Authorization is required)	The Corporation pays 70% of the Allowable Charge after the Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Copayment	The Corporation pays 50% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Lab, x-ray and other diagnostic services	The Corporation pays 100% of the Allowable Charge	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
True Emergency Room Visits (Copayment waived if admitted)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $50 Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $50 Copayment The Member must pay the balance of the Provider's charge
Non-true Emergency Room Visits (Copayment waived if admitted)	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $50 Copayment The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $50 Copayment The Member must pay the balance of the Provider's charge
All other covered outpatient Benefits	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 30% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge